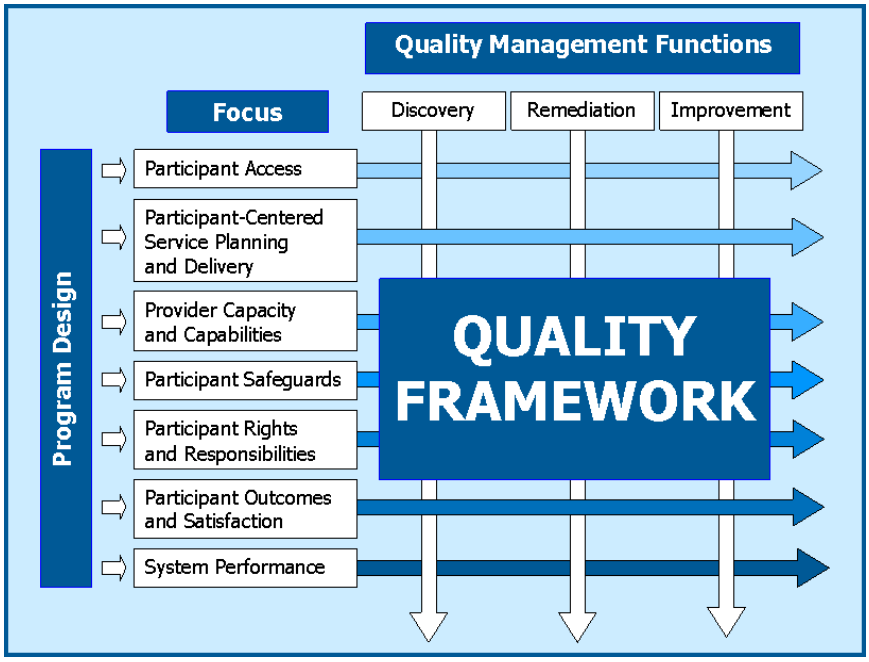
Appendix H: Quality Management Strategy



Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement. A Quality Management Strategy is explicitly describes the processes of discovery, remediation and improvement; the frequency of those processes; the source and types of information gathered, analyzed and utilized to measure performance; and key roles and responsibilities for managing quality.

CMS recognizes that a state's waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

1. **The Quality Management Strategy must describe how the state will determine that each waiver assurance and requirement is met.** The applicable assurances and requirements are: (a) level of care determination; (b) service plan; (c) qualified providers; (d) health and welfare; (e) administrative authority; and, (f) financial accountability. For each waiver assurance, this description must include:
   - Activities or processes related to discovery, i.e. monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery are provided in the application in Appendices A, B, C, D, G, and I. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance. The description of the Quality Management Strategy should not repeat the descriptions that are addressed in other parts of the waiver application;
   - The entities or individuals responsible for conducting the discovery/monitoring processes;
   - The types of information used to measure performance; and,
   - The frequency with which performance is measured.
2. **The Quality Management Strategy must describe roles and responsibilities of the parties involved in measuring performance and making improvements. Such parties include (but are not limited to) the waiver administrative entities identified in Appendix A, waiver participants, advocates, and service providers.**

   Roles and responsibilities may be described comprehensively; it is not necessary to describe roles and responsibilities assurance by assurance. This description of roles and responsibilities may be combined with the description of the processes employed to review findings, establish priorities and develop strategies for remediation and improvement as specified in #3 below.
3. **Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement.** *The description of these process(es) employed to review findings, establish priorities and develop strategies for remediation and improvement may be combined with the description of roles and responsibilities as specified in # 2 above.*
4. **The Quality Management Strategy must describe how the State compiles quality management information and the frequency with which the State communicates this information (in report or other forms) to waiver participants, families, waiver service providers, other interested parties, and the public.** *Quality management reports may be designed to focus on specific areas of concern; may be related to a specific location, type of service or subgroup of participants; may be designed as administrative management reports; and/or may be developed to inform stakeholders and the public.*
5. **The Quality Management Strategy must include periodic evaluation of and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy.**

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

Attachment #1 to Appendix H

The Quality Management Strategy for the waiver is:

The State has a Quality Assurance Plan that identifies key components and practices of the Quality Framework methodology. Within this working document, the following guidelines are monitored: Level of Care Determination Consistent with Need for Institutionalization, Plans of Care Responsive to Waiver Participant Needs, Qualified Providers Service Waiver Participants, Health & Welfare of Waiver Participants, State Medicaid Agency Retains Administrative Authority Over the Waiver Program, and Provision of Financial Accountability for the Waiver.

In order to evaluate the effectiveness and outcomes of the above guidelines, the State has adopted a method by using discovery, remediation, improvement plans, and evaluation of effectiveness.

For the Level of Care guideline, the State reviews information gathered from:

- HCBS reviews of Case Management - data is evaluated by program administration to ensure level of cares are verified.

- Reports generated from Dual Diagnosis Management. Quarterly reports are compared to screening information and payment information. Program administration follows-up directly with the County and/or service provider. Payment adjustments occur when improper billing practices have been determined.

- HCBS reviews of Case Management data support that individuals are offered Medicaid Waiver services when an individual appears to be eligible for a Waiver program.

- HCBS requests input from providers to assure Case Managers understand the LOC process.

- HCBS reviews of Case Management data to evaluate that assessments, reassessments, and contacts are made in accordance with Waiver assurances and HCBS policy.

When pre-determined (QA) goals are not met, the State will discuss at Team meetings and develop a plan of action. The results of the data are also published and provided to Case Management entities. If goals are unmet, the issue will be addressed further in the next Case Management training. Policy/protocol are updated as applicable.

For the Plan of Care guideline, the State reviews information gathered from:

- HCBS reviews of Case Management – data is evaluated to assure outcomes are documented when certain impairment criteria have been met. Also evaluation is made to assure the service matching the need has been authorized.
- Copies of care plans forwarded to the State. Program Administration assures client goals are identified and follows through with Case Manager when needed.
- Input hearings identifying potential, unmet needs of consumers.

When pre-determined goals are not met, the State will discuss at Team meetings and develop a plan of action. The results of the data are also published and provided to Case Management entities. If goals are unmet, the issue will be addressed further in the next Case Management training. Tools and/or instruments are revised to accommodate new measures. Policy/protocol are updated as applicable.

For Qualified Service Providers, the State reviews information gathered from:

- Provider reviews to assure provider qualifications are in order, providers are delivering services within pre-determined standards, and provider's records are in order and billing within authorizations.

The State also periodically reviews provider enrollment documents to ensure efficiency and effectiveness of the enrollment process.

The State has been updating policy chapters, administrative code, and protocols as applicable. Training materials are developed and/or revised as indicated.

When pre-determined goals are not met, the State will discuss at Team meetings and develop a plan of action. The results of the data are also published and provided to Case Management entities. If goals are unmet, the issue will be addressed further in the next Case Management training. Tools and/or instruments are revised to accommodate new measures.

Case Managers and other service providers are notified of actions when applicable. If improper payment activities have occurred, adjustments to claims are processed.

For Health & Welfare guidelines, the State gathers information from:

- Consumer & provider input to assure Case Managers are aware of protocol to report complaints.
- Complaint logs for evaluation/remediation.
- Client Interviews to assure the services they are receiving meet their needs and expectations, are aware of their rights, and their social needs and community involvement meets their expectations

When pre-determined goals are not met, the State will discuss at Team meetings and develop a plan of action. The results of the data are also published and provided to Case Management entities. If goals are unmet, the issue will be addressed further in the next Case Management training. Policy/protocol are updated as applicable.

For the State's Administrative Authority, the State gathers information from:

- The payment system to evaluate and review payment/actions to reduce inaccurate claims for payment.
- Provider logs to cross reference with billing activity to assure providers are claiming payment for services rendered in accordance with authorizations and provider standards.

When issues are found with the payment records or provider records, the issues are resolved by Findings/Corrective Actions and adjustments to the payment system. The State will terminate provider status if the issue has been determined to be extreme or evidence support fraudulent activities.

The State reports findings to the provider. Protocols, policy, and Administrative Code are updated as applicable.

There are two HCBS Reviewers who are responsible for the Case Management and Provider Reviews and for conducting Client Interviews. In addition, two other program administrators offer backup.

One of the Reviewers also has the responsibility of provider enrollment while the other is responsible for provider complaints. Program Administration is responsible for training or technical assistance provided to Case Managers.

The HCBS Unit of the ND Medical Services Division has partnerships with other Units within the Medical Services Division. The HCBS Team includes the all staff member of the HCBS Staff, and the Managed Care/PACE/Disease Management Program Administrator, the LTC Program Administrator, the State Unit on Aging Director, and Assistant Medical Services Director.

The HCBS program administration has partnered on projects with the Developmental Disabilities Division, Vocational Rehabilitation Division, Aging Services Division, and the Department's Tribal Liaison. With these partnerships consumers needs and issues can be addressed and streamlined.

External resources are vital to the development of effective and efficient services. These entities participate as applicable: County Social Service Boards, service providers, family members, consumers, Home Health Agencies, Long Term Care Association, advocates, plus others.

With any working document, the above guidelines and goals are evaluated and the measurements are accordingly revised or adjusted. Goals will be able to be measured annually or as needed to identify improvement or additional modifications to the QA plan or HCBS process.